FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008490

Facility Name: Fair Oaks

Address: 200 Health Care Drive (Number) Greenville (City) 62246 (Zip Code)

County: Bond

Telephone Number: 618-664-1230 **Fax #** 618-664-9750

IDPA ID Number: 37-0792770003

Date of Initial License for Current Owners: 11/01/69

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 501-C-3

In the event there are further questions about this report, please contact:
Name: Jerry Graber **Telephone Number:** 618-664-1230 ext.3100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Jerry Graber

(Title) CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) NONE

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 10/01/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,461	10,581	2,791	31,833	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,461	10,581	2,791	31,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.75%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/69

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 108 and days of care provided 2,791

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Fair Oaks # 0008490 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	272,532	28,765	14,177	315,474	(79,384)	236,090	86,178	322,268			1
2	Food Purchase		186,020		186,020		186,020		186,020			2
3	Housekeeping	83,303	18,609		101,912		101,912	26,525	128,437			3
4	Laundry	88,491	19,635		108,126		108,126	96,970	205,096			4
5	Heat and Other Utilities			202,200	202,200		202,200		202,200			5
6	Maintenance	88,732	63,873		152,605		152,605	44,870	197,475			6
7	Other (specify):* Support Svcs	24,858	1,886		26,744		26,744		26,744			7
8	**TOTAL General Services**	557,916	318,788	216,377	1,093,081	(79,384)	1,013,697	254,543	1,268,240			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,657,238	91,695		1,748,933		1,748,933		1,748,933			10
10a	Therapy			3,381	3,381		3,381		3,381			10a
11	Activities	43,225	5,087		48,312		48,312	(692)	47,620			11
12	Social Services	53,100	744	2,070	55,914		55,914		55,914			12
13	CNA Training	69,077	17,551		86,628	(53,107)	33,521	(32,211)	1,310			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,822,640	115,077	5,451	1,943,168	(53,107)	1,890,061	(32,903)	1,857,158			16
	C. General Administration											
17	Administrative	121,739	15,858		137,597	(16,105)	121,492		121,492			17
18	Directors Fees											18
19	Professional Services			528	528		528		528			19
20	Dues, Fees, Subscriptions & Promotions			9,919	9,919	16,105	26,024	(16,105)	9,919			20
21	Clerical & General Office Expenses	54,927	47,967		102,894		102,894	7,796	110,690			21
22	Employee Benefits & Payroll Taxes			469,939	469,939	79,384	549,323	(5,743)	543,580			22
23	Inservice Training & Education					53,107	53,107		53,107			23
24	Travel and Seminar			4,843	4,843		4,843		4,843			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			45,781	45,781		45,781		45,781			26
27	Other (specify):* PTO-HR	16,305	4,832		21,137		21,137		21,137			27
28	**TOTAL General Administration**	192,971	68,657	531,010	792,638	132,491	925,129	(14,052)	911,077			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,573,527	502,522	752,838	3,828,887		3,828,887	207,588	4,036,475			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fair Oaks #0008490 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			113,743	113,743		113,743	12,045	125,788			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Minor Equipment**			949	949		949		949			36
37	**TOTAL Ownership**			114,692	114,692		114,692	12,045	126,737			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,878	2,168	75,046		75,046		75,046			39
40	Barber and Beauty Shops			7,953	7,953		7,953	(7,971)	(18)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,130	59,130		59,130		59,130			42
43	Other (specify):* **Bad Debts**											43
44	**TOTAL Special Cost Centers**		72,878	69,251	142,129		142,129	(7,971)	134,158			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,573,527	575,400	936,781	4,085,708		4,085,708	211,662	4,297,370			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,785)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(7,971)	40		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(692)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,105)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(32,211)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,764)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	290,426	Page 6	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 290,426		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 211,662		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Fair Oaks

ID# **0008490**

Report Period Beginning: **01/01/05**

Ending: **12/31/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Fair Oaks **# 0008490** **Report Period Beginning: 01/01/05** **Ending: 12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(692)	0	0	0	0	0	0	0	0	0	0	(692)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(32,211)	0	0	0	0	0	0	0	0	0	0	(32,211)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(32,903)	0	0	0	0	0	0	0	0	0	0	(32,903)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(16,105)	0	0	0	0	0	0	0	0	0	0	(16,105)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(21,785)	0	0	0	0	0	0	0	0	0	0	(21,785)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(37,890)	0	0	0	0	0	0	0	0	0	0	(37,890)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(70,793)	0	0	0	0	0	0	0	0	0	0	(70,793)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Fair Oaks **#** 0008490 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(7,971)	0	0	0	0	0	0	0	0	0	0	(7,971)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(7,971)	0	0	0	0	0	0	0	0	0	0	(7,971)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(78,764)	0	0	0	0	0	0	0	0	0	0	(78,764)	45

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Greenville Regional Hospital, Inc.	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		MAINTENANCE	$ 104,698		0.00%	$ 149,568	$ 44,870	1
2	V		LAUNDRY	59,433		0.00%	156,403	96,970	2
3	V		HOUSEKEEPING	64,940		0.00%	91,465	26,525	3
4	V		DIETARY	86,178		0.00%	172,356	86,178	4
5	V		TELEPHONE SYSTEM	70,167		0.00%	77,963	7,796	5
6	V		BENEFITS-LAB&X-RAY SVCS	91,255		0.00%	99,082	7,827	6
7	V		BENEFITS-PHARMACY	34,876		0.00%	43,091	8,215	7
8	V		HOSPITAL SHARED AREA			0.00%		45,765	8
9	V		FAIR OAKS SHARED AREA			0.00%		(33,720)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 511,547			$ 789,928	$ * 290,426	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Greenville Regional Hospital
Street Address: 200 Healthcare Drive
City / State / Zip Code: Greenville, Illinois 62246
Phone Number: (618-664-1230
Fax Number: (618-664-9750

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	Note:	Greenville Regional Hospital, Inc. operates Greenville Regional Hospital & Fair Oaks.								2
3		Fair Oaks is charged for all known direct costs of operation.								3
4		Fair Oaks shares cost with the hospital for certain services & therefore receives all allocations.								4
5										5
6		The following departments have costs allocated to Fair Oaks:								6
7										7
8		Maintenance of Plant								8
9		Laundry								9
10		Housekeeping								10
11		Dietary								11
12		Utilities & Telephone								12
13		Depreciation (Only of those departments that share services)								13
14		Administration and General								14
15		Financial Services								15
16		HR & Staff Benefits								16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Fair Oaks # 0008490 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	Non Profit	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME _____ COUNTY _____

FACILITY IDPH LICENSE NUMBER _____

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,896 B. General Construction Type: Exterior Brick Frame Metal Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		259,875	1957	$	1
2					2
3	TOTALS	259,875		$	3

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1969	1969	$ 992,165	$		$	$	$	4
5	49		1974	1974	367,348						5
6			1981	1981	59,093						6
7											7
8											8
	Improvement Type**										
9				1969	6,835						9
10				1972	927						10
11				1974	6,528						11
12				1975	3,058						12
13				1980	543						13
14				1982	17,661						14
15				1984	66,863						15
16				1985	7,721						16
17				1986	10,764						17
18				1987	30,588						18
19				1988	30,786						19
20				1989	15,099						20
21				1990	25,662						21
22				1991	26,807						22
23				1992	23,815						23
24				1997	9,666						24
25				1998	23,932						25
26				1999	76,550						26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	North Wing Renovation	2000	$ 14,734	$		$	$	$	37
38	South Wing Automatic Door Installation	2000	4,929						38
39	Activities Room Renovation	2000	8,653						39
40	Parking Lot Expansion	2000	135,861						40
41									41
42	East Wing HVAC Repair	2001	18,150						42
43									43
44	Canopy Project	2002	179,280						44
45	East Wing HVAC Repair	2002	29,040						45
46									46
47	North Wing Nurse's Station Renovated	2003	6,794						47
48									48
49	HVAC Units Replaced	2004	18,230						49
50	Dinning Room Renovated	2004	42,249						50
51	Scheduling Office Renovated	2004	3,400						51
52									52
53	Fire Dampers	2005	23,173						53
54	Shower Room Renovation	2005	7,034						54
55	Roof Replacement	2005	16,579						55
56									56
57	Retirements	2005	(21,378)						57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,289,139	$ 74,303		$ 74,303	$ 94,718	$ 1,521,154	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 520,226	$ 30,849	$ 30,849	$		$ 492,766	71
72	Current Year Purchases	42,177	4,392	4,392			4,392	72
73	Fully Depreciated Assets	(78,456)					(76,288)	73
74	Adjustments	(3,734)					(119,830)	74
75	TOTALS	$ 480,213	$ 35,241	$ 35,241	$		$ 301,040	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Activities	Ford Bus-2004	2004	$ 42,000	$ 4,200	$ 4,200	$		$ 6,300	76
77										77
78										78
79										79
80	TOTALS			$ 42,000	$ 4,200	$ 4,200	$		$ 6,300	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,811,352	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 113,744	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 113,744	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,828,494	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NONE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [X] YES
   - [ ] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM: [X]
   - IN OTHER FACILITY: [ ]
   - COMMUNITY COLLEGE: [ ]
   - HOURS PER CNA: 80

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM: [X]
   - IN OTHER FACILITY: [ ]
   - HOURS PER CNA: 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies			10,169	10,169
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)			23,352	23,352
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$ 33,521	$ 33,521
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$ 32,211

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	79
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	1
TOTAL TRAINED	80

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts			2,168	72,878		75,046	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 2,168	$ 72,878		$ 75,046	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fair Oaks # 0008490 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 728,681	$ 993,312	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,100,000)	3,548,862	3,548,862	3
4	Supply Inventory (priced at)	387,711	387,711	4
5	Short-Term Investments	519,352	519,352	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	340,184	340,184	7
8	Accounts Receivable (owners or related parties)	5,078		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,529,868	$ 5,789,421	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	33,197,942	35,818,009	16
17	Accumulated Depreciation (book methods)	(11,850,914)	(12,783,412)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	868,432	7,120,202	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	423,473	785,273	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 22,638,933	$ 30,940,072	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 28,168,801	$ 36,729,493	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,179,611	$ 1,179,611	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	519,657	519,657	29
30	Accrued Salaries Payable	627,956	627,956	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	89,652	89,352	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	34,821		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	216,230	250,616	36
37	Due to Medicare	33,224	33,224	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,701,151	$ 2,700,416	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,086,989	11,086,989	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Residency Fees	842,211	842,211	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 11,929,200	$ 11,929,200	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 14,630,351	$ 14,629,616	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,538,450	$ 22,099,877	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 28,168,801	$ 36,729,493	48

***(See instructions.)**

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,731,353	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,731,353	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(968,249)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Hospital-Net Income**	2,011,544	15
16	Other (describe) **Emerald Pointe-Net Loss**	(41,230)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,002,065	17
	B. Transfers (Itemize):		
18			18
19	**Due to Affiliated Organizations**	(194,968)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (194,968)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 13,538,450	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,617,454	1
2	Discounts and Allowances for all Levels	(540,869)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,076,585	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	32,211	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,971	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	692	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 40,874	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,117,459	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,093,081	31
32	Health Care	1,943,168	32
33	General Administration	792,638	33
	B. Capital Expense		
34	Ownership	114,692	34
	C. Ancillary Expense		
35	Special Cost Centers	82,999	35
36	Provider Participation Fee	59,130	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,085,708	40
41	**Income before Income Taxes (line 30 minus line 40)****	(968,249)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (968,249)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,060	6,247	$ 127,198	$ 20.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,918	12,244	259,623	21.20	3
4	Licensed Practical Nurses	15,589	19,246	315,634	16.40	4
5	CNAs & Orderlies	67,409	83,221	939,492	11.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,255	4,018	43,225	10.76	9
10	Activity Assistants					10
11	Social Service Workers	3,362	4,151	53,100	12.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,647	24,256	272,532	11.24	15
16	Dishwashers					16
17	Maintenance Workers	4,559	5,628	88,732	15.77	17
18	Housekeepers	7,278	8,985	83,303	9.27	18
19	Laundry	7,333	9,053	88,491	9.77	19
20	Administrator	3,373	4,164	113,212	27.19	20
21	Assistant Administrator					21
22	Other Administrative	172	212	3,154	14.88	22
23	Office Manager					23
24	Clerical	3,282	4,052	54,927	13.56	24
25	Vocational Instruction	2,498	3,084	69,077	22.40	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	194	240	5,373	22.39	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	936	1,156	15,291	13.23	31
32	Other Health Ca PTO & HR	641	791	16,305	20.61	32
33	Other(specify) Support Svcs	948	1,170	24,858	21.25	33
34	TOTAL (lines 1 - 33)	155,454	191,918	$ 2,573,527 *	$ 13.41	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 14,177	1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,168	39	39
40	Physical Therapy Consultant		3,381	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,070	12	45
46	Other(specify) Beauty Shop		7,953	40	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 29,749		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alan Harnetiaux	Administrator	0	$ 88,729
Mary Compton	Admin Assistant	0	24,483
Ryan Mifflin	Marketing	0	3,154
Lisa Beck	Quality Mgmt	0	5,373
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 121,739

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Verify	Criminal Check	$ 528
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 528

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,560
Unemployment Compensation Insurance	7,028
FICA Taxes	130,608
Employee Health Insurance	198,533
Employee Meals	79,384
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	80,220
Dental Plan	5,151
Staff Dinners	3,603
Life Insurance	1,832
Staff Gifts	1,849
Medical Svcs Provided to Staff	8,597
Income from Staff Meal Sales	(21,785)
TOTAL (agree to Schedule V, line 22, col.8)	$ 543,580

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA	9,452
Other Dues	468
Marketing Salaries	3,154
Marketing Expenses	9,838
Advertisisng	3,113
Less: Public Relations Expense	( )
Non-allowable advertising	(16,105)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,920

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,752
Seminar Expense	3,092
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,844

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-$9,452**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **59,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **79,384** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **21,785**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **None**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD,LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$